MARYLAND

MARYLAND HEALTH BENEFIT EXCHANGE

Exchange Implementation Advisory Committee

March 8, 2012

Agenda

1. **Welcome / Introductions**

2. **Exchange Implementation Testing Approach**
   - **Early Interoperability**

3. **Plan Management**
   - **QHP Certification Requirements**

4. **JAD Session Recap**

5. **SHOP Update**

6. **Schedule Review / Next Steps**

Implementation Advisory Committee Charter

Purpose: Forum for the Maryland Health Benefit Exchange (the Exchange) to engage with industry partners to discuss and receive advice on matters pertaining to the implementation of key operational and technical integration points between the Exchange and its partners

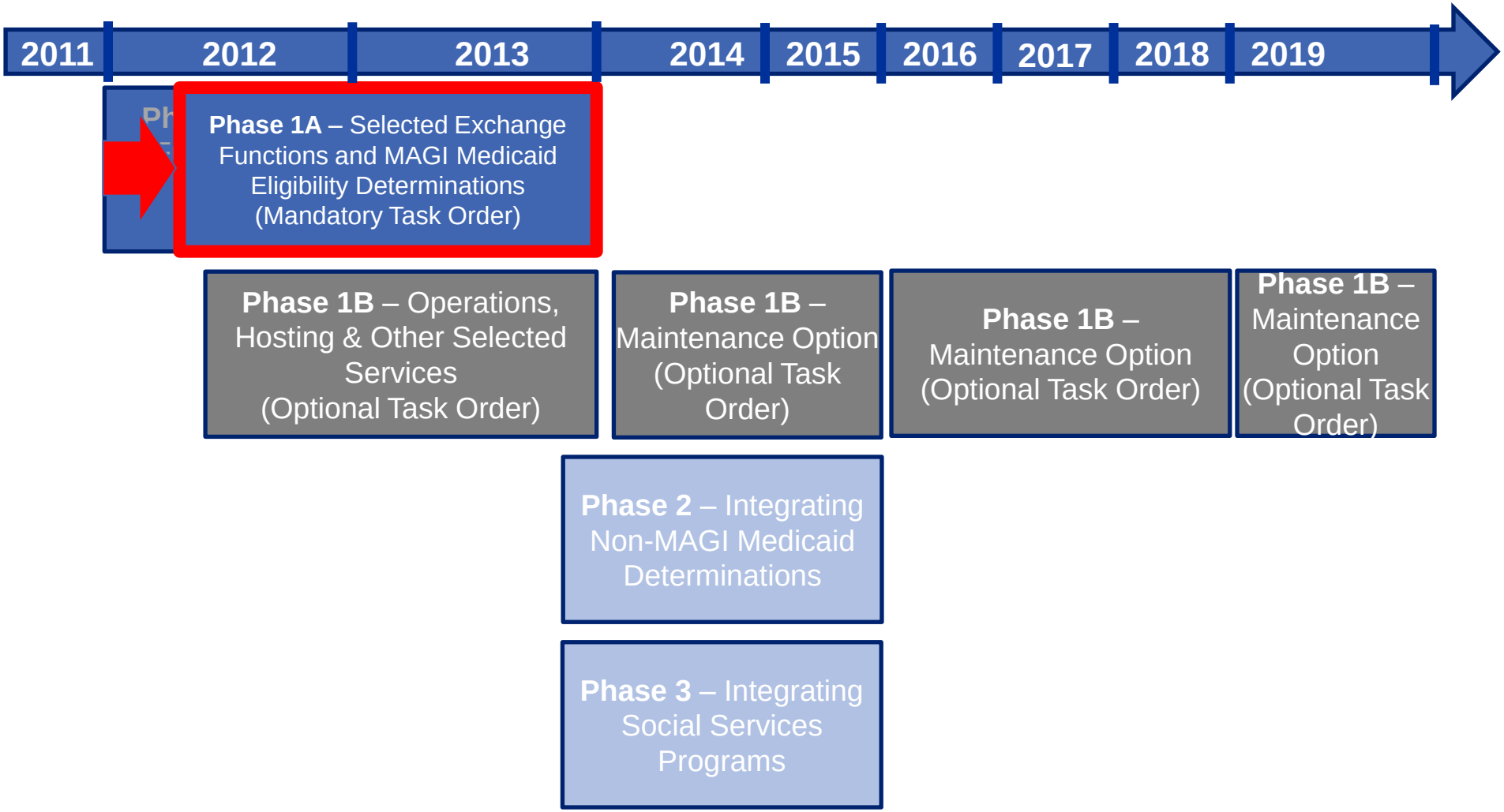
Objectives:

- Establish and maintain a dialog between the Exchange and industry to discuss key decision points, timelines, issues, and risks, obtaining the advice of industry experts on these matters
- Ensure that common interfaces and integrated business processes between the Exchange and industry are:
  - Transparent
  - Standards-driven
  - Supportive of maximum automation and reuse
  - Efficient and equitable
- Serve as conduit for the identification of specific subject matter expertise within industry to work in collaboration with the Exchange on detailed requirements and design sessions

Exchange Implementation Testing Approach

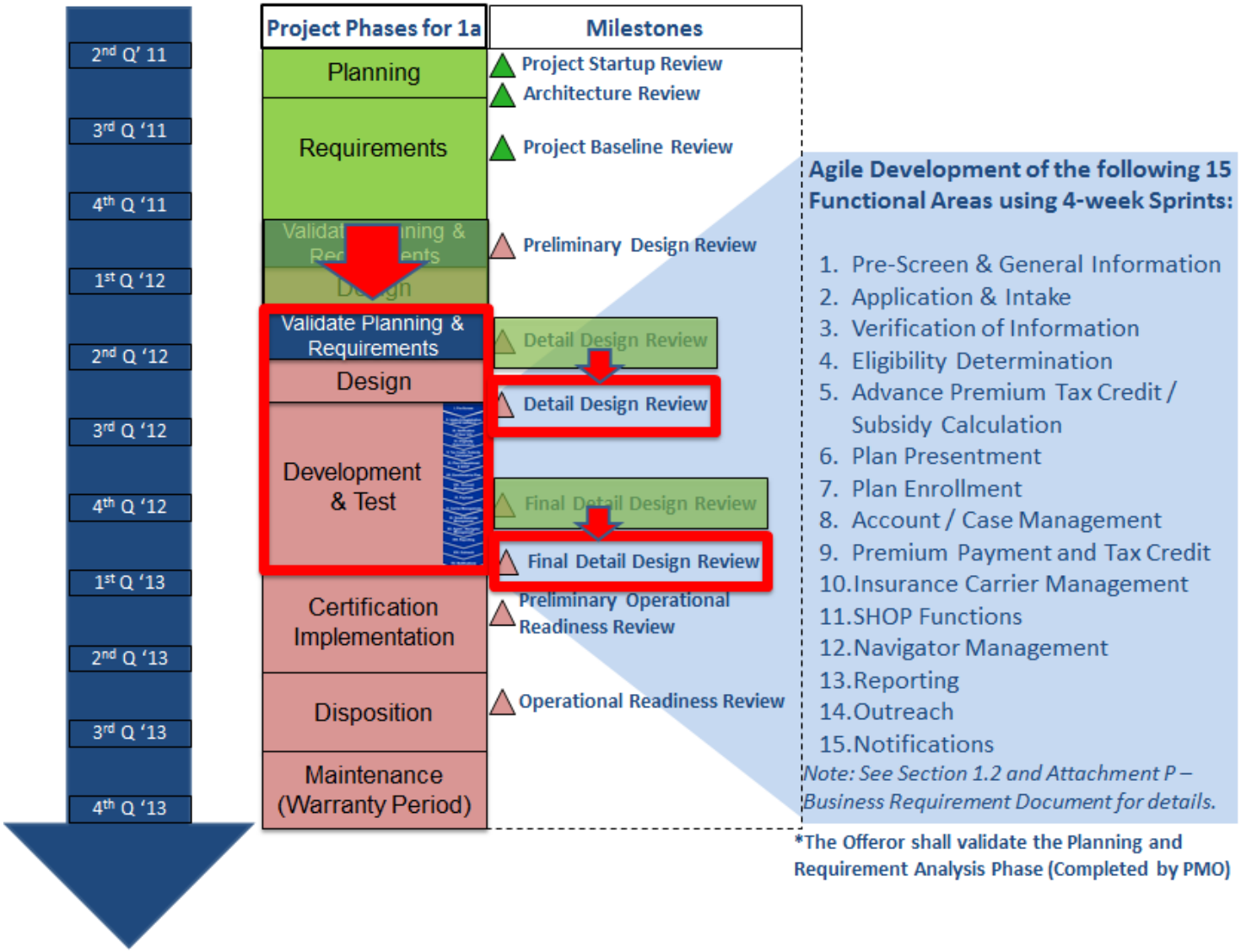
High-Level Timeline

- Following adjusted high-level timeline illustrates that based on our current delays we would be compressing Phase 1A already by two months. Maryland **does not** have the flexibility to extend the end date as it driven by ACA.



Detailed Project Timeline

- Following detail timeline illustrates that based on current delays, we compress the Development & Test by almost a full quarter. Additionally, DDR & FDDR milestone is also extended by the same.

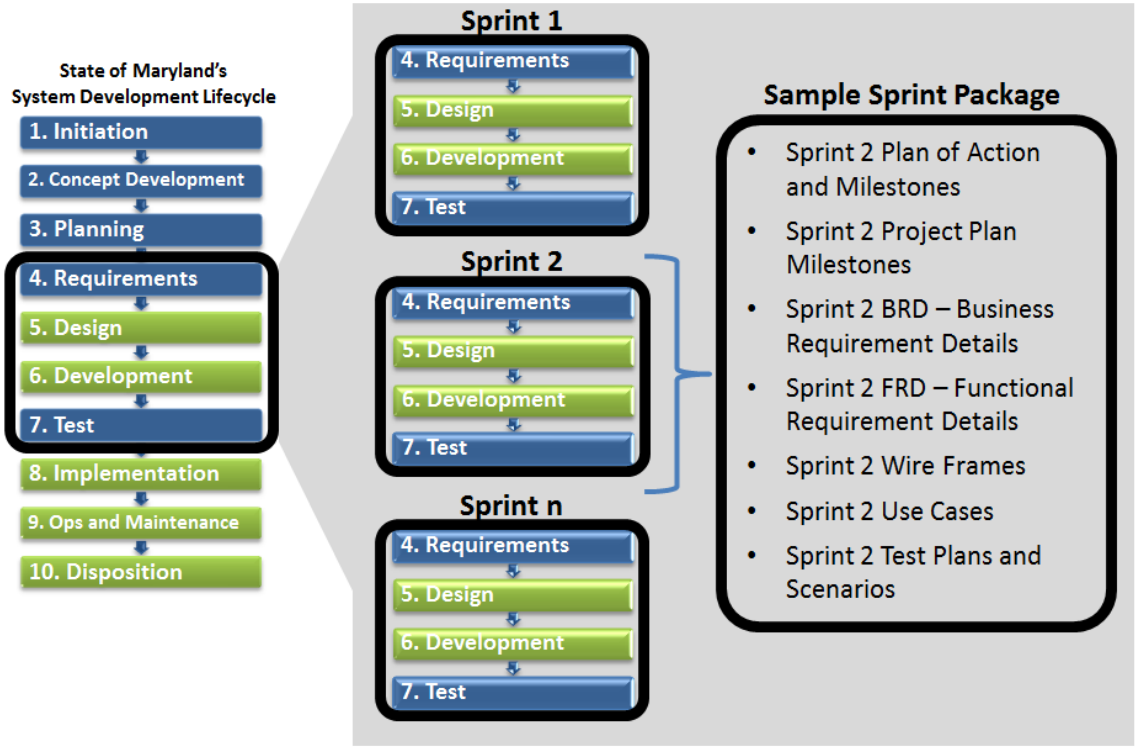


Maryland **<u>does not</u>** have the flexibility to change the date of Certification that is set by ACA to be **<u>January 1, 2013.</u>**

Agile Implementation Approach

MD agile development approach utilizes the Sprint methodology, which allows for Testing to be an integral and integrated component of the development approach.

- User Acceptance Testing (UAT) is part of each Sprint
- In addition to UAT, the Exchange will also conduct interoperability testing (where applicable)

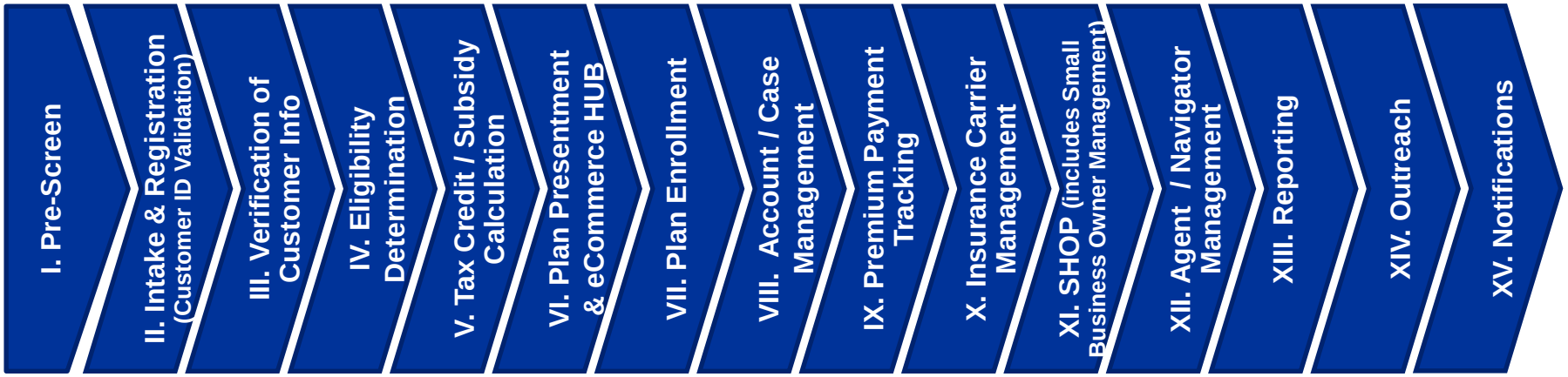


Interoperability testing will include:

- Defining the format of the Exchange output
- Converting Exchange input (as required)
- Ensuring that data input matches data output for the defined Sprint

Sprints and Required Stakeholders

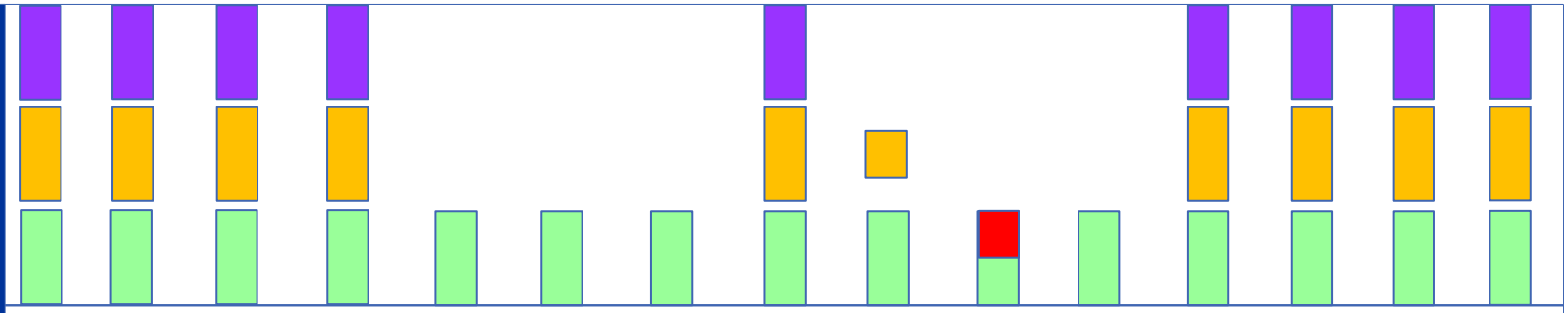
Following is illustration of when potential stakeholders could be required, respective to each sprint.



Timeframe

We will be working with the IT Vendor and CMS to identify what portion are required by 1/1/2013 for (conditional) certification and will be updating the timeline respectivelyl

Stakeholders*



*Stakeholder's include Executive Champion, Policy, End-User as well as Technology experts.

Enrollment Transaction Testing

- Initial testing will focus on enrollment transactions and the key components associated with the eligibility and enrollment functions:
  - Are all of the applicable enrollment application fields there?
  - Is the enrollment information in a compatible format?
  - Updates / Special Enrollments?
- This testing will take place between the Exchange and select external stakeholders (Carriers, TPA's, etc.) that contain the IT infrastructure required to meet the testing requirements
- A test environment will be utilized and tested sprints will be stored in a staging area for future integrated end-to-end testing once all the Sprints are developed.

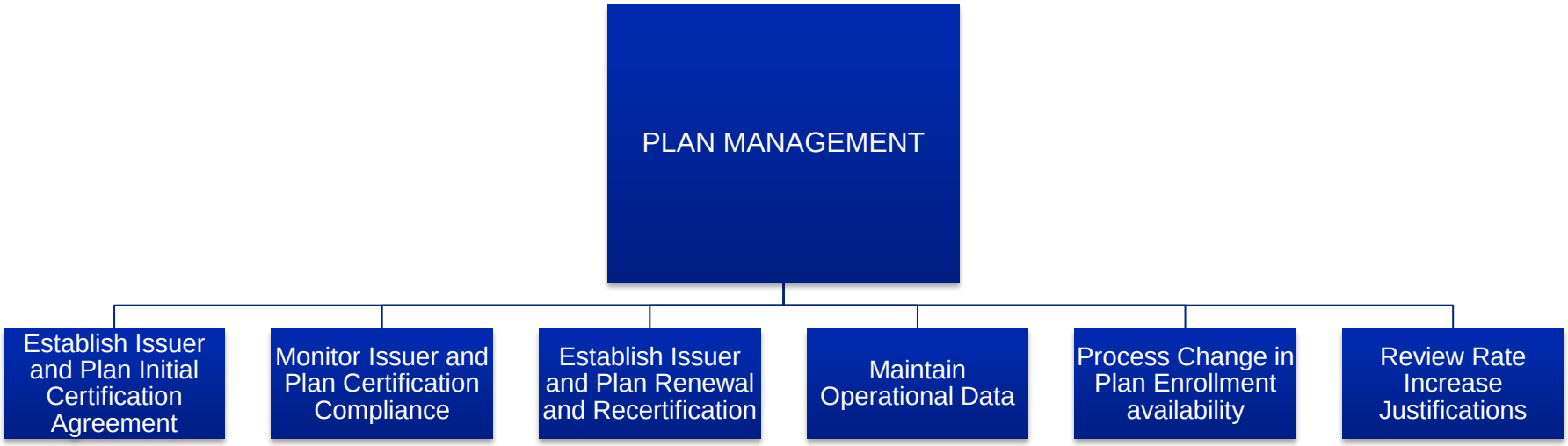
NOTE: The Exchange will conduct end-to-end integration testing at the conclusion of the Sprint development cycle.

Plan Management – QHP Certification Requirements

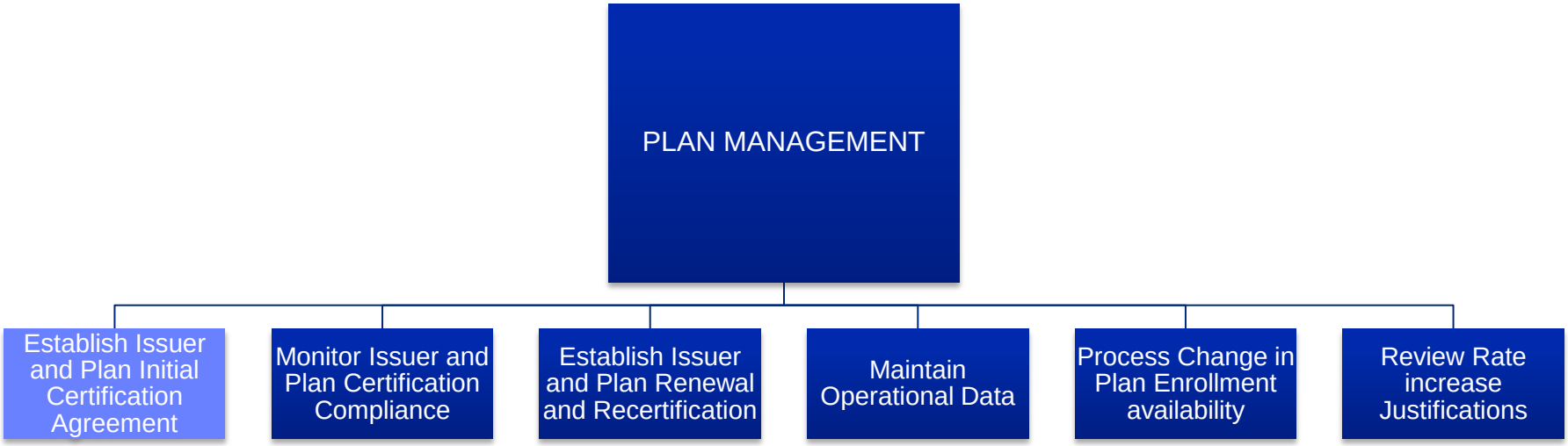
Plan Management - Business Overview

Plan Management encompasses all activities associated with certifying/recertifying/de-certifying plans, monitoring compliance, managing operational data and plan enrollment availability and approving/reviewing rates.

The Exchange and the MIA are collaborating to identify the workflows associated with Plan Management.



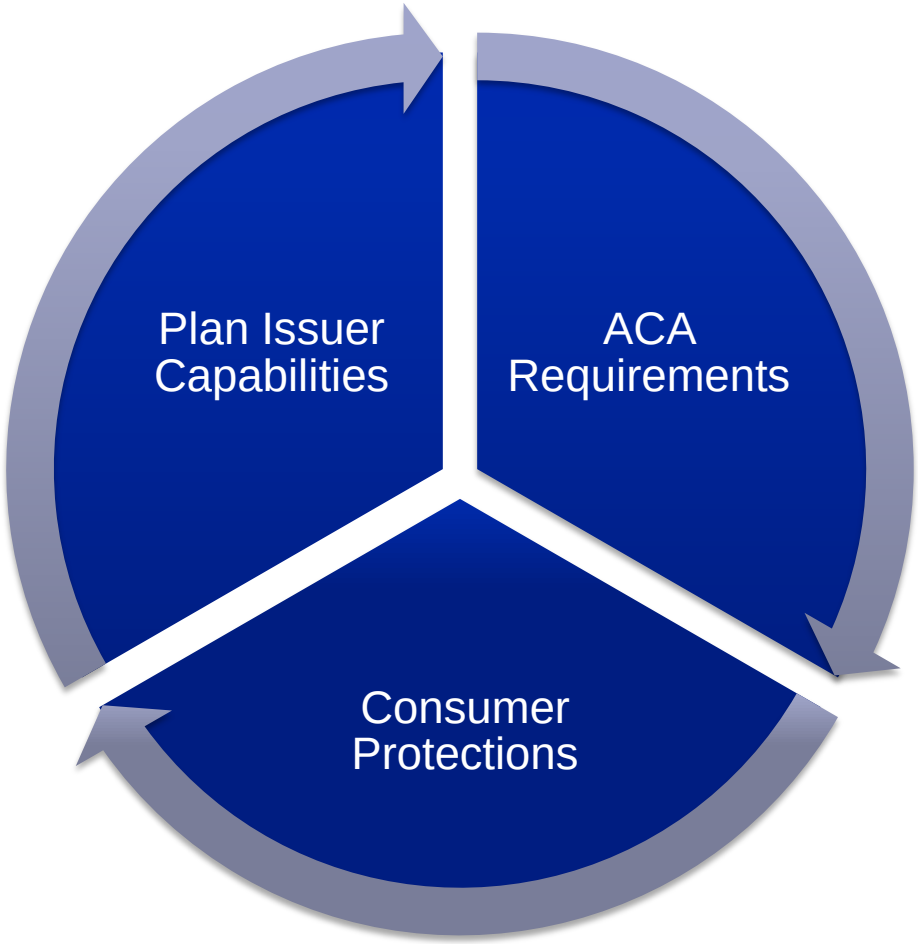
Plan Management Business Area Overview



Plan Certification Strategy – A Balanced Approach

- The Maryland Health Benefit Exchange must establish a balanced approach to its plan certification requirements

- The ACA requirements, consumer needs and plan issuer capabilities must be be considered as the certification process is developed.



Plan Certification Elements

Based on ACA requirements, the following elements will be required for the Exchange to certify qualified health plans (QHPs).

- Rate & Form Review
- Accreditation
- Network Adequacy
- Benefit Design Standards
  - Essential Health Benefits
  - Limitations on Cost-Sharing
  - Actuarial Value Requirements
- Discriminatory Benefit Design
- Quality evaluation
- Transparency Information

Decisions will need to be made about the certification requirements for qualified dental plans (QDPs) and qualified vision plans (QVPs).

This list is not exhaustive. Final plan certification requirements for QHPs, QDPs and QVPs will be released by the Exchange by Q4 2012.

Rate & Form Review

The Rate & Form review process will continue to be managed by the Maryland Insurance Administration through the System for Electronic Rate and Form Filing (SERFF).

In order for carriers to correctly report ACA related filings to the Maryland Insurance Administration (MIA), NAIC will be implementing new fields in SERFF to distinguish QHP filings.

QHP Products would need to be filed with the MIA for:

- Initial filing
- Rate increases

Rate & Form Review

The ACA restricts the variation of premiums, both inside and outside the Exchange to the following rating factors:

- Age (3:1 max)
- Tobacco Use (1.5:1 max)
- Rating Area
- Family Composition – only 4 types allowed
  - Individual
  - Two adults
  - Adult plus child
  - Family

Accreditation

A QHP issuer must:

a) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:
   - Clinical quality measures, such as Health care Effectiveness Data and Information Set (HEDIS)
   - Patient experience ratings on a standardized CAHPS survey
   - Consumer access
   - Utilization management
   - Quality assurance
   - Provider credentialing
   - Complaints and appeals
   - Network adequacy and access
   - Patient information programs

b) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

Accreditation can take 12-18 months. The Exchange could offer a grace period within which a QHP issuer must become accredited following its initial certification.

Network Adequacy

A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards:

- General requirement:
  - Includes essential community providers
  - Complies with any network adequacy standards established by the Exchange
  - Is consistent with the network adequacy provisions of the Public Health Service Act

- Notice to applicants and enrollees:
  - A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online pursuant to guidance from the Exchange and to potential enrollees in the hard copy upon request.
  - In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

Benefit Design Standards

Essential Health Benefits

The Essential Health Benefits benchmarking process is being lead by the Health Care Reform Coordinating Council. The expected completion date for defining Maryland's Essential Health Benefits package is October 1, 2012.

The categories that must be included are:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care

Benefit Design Standards

Limitations on Cost-Sharing

Out-of-Pocket Limits:

• Cost sharing under a plan may not exceed $6,050 for self-only coverage or $12,100 for other coverage

Deductibles:

•Employer-sponsored plans may not have a deductible in excess of $2,000 for a plan covering a single individual or $4,000 for other coverage

- The deductible limit may be increased by the maximum amount of reimbursement reasonably available to an employee under a flexible spending arrangement.

Beginning in 2015, all of the cost-sharing limits will be indexed to per-capita growth in premiums in the United States as determined by HHS.

Benefit Design Standards

Actuarial Value Requirements

Section 1302 of the ACA requires non-grandfathered plans to meet one of four levels of coverage based upon the average percentage of costs for EHBs:

- Platinum plans: 90% actuarial value
- Gold plans: 80% actuarial value
- Silver plans: 70% actuarial value
- Bronze plans: 60% actuarial value

On February 24th, HHS issued guidance that allows plans to vary from the specified actuarial values for each metal tier by +/- 2 percentage points.

On February 29th, CCIIO issued a bulletin indicating that they would be providing an AV tool that could be used by states and carriers to calculate AV.

Discriminatory Benefit Design

The ACA requires that QHP issuers not discriminate against individuals because of their age, disability, or expected length of life.

QHP issuers must meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs.

No additional federal guidance is available at this time.

Quality

HHS requires the Exchange to evaluate QHP's quality improvement strategies and oversee implementation of enrollee surveys and of assessments and ratings of health care quality and outcomes.

No additional federal guidance is available at this time.

Transparency Information

Transparency information an ACA requirement. QHP issuers will need to provide the following information:

- Summary of benefits and coverage
- Metal level (bronze, silver, gold, or platinum or catastrophic)
- Enrollee satisfaction survey results
- Quality ratings
- Medical Loss ratio
- The provider directory
- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment/disenrollment
- Data on number of claims that are denied
- Data on rating practices
- Information on cost-sharing and payments with respect to out-of-network coverage
- Information on enrollee rights
- Upon request of an individual, information on cost-sharing with respect to a specific item/service

Questions

- What criteria should stand-alone dental plans adhere to in order to qualify as Qualified Dental Plans on the Exchange?
- What criteria should stand-alone vision plans adhere to in order to qualify as Qualified Vision Plans on the Exchange?
- If the Exchange were to limit the # of plans that could be offered by each carrier, would that be problematic?
- What is the appropriate number of plans to be offered by each carrier?

JAD Session Recap

JAD Session Overview

Summary:

- The group has completed two JAD Sessions:
  - Eligibility and Enrollment
  - Plan Management
- The discussions and feedback have been extremely valuable to our team and has helped shape the path forward for certain components of the Exchange

Approach:

- The JAD Session participants walk through user scenarios utilizing wireframes that the PMO team has developed
- These wireframes are used to help story board the process by which a user would encounter in order to complete the functions outlined within the scenarios
- The wireframes are supplemented with additional open discussion questions around topics that are not process oriented

Plan Management

Key Findings:

- What is “Real-Time” enrollment – what are the effective dates associated with Exchange enrollment
- Would be beneficial to include a “Quick Quote” capability for small business
  - Exchange to work with Stakeholders to define what data fields are necessary for this function
- Process flow for how things are done in the market place today does not match assumptions captured in wireframes
  - Input Roster Information – Compare Plans – Select Model - …
- Plan model (Defined Benefit vs. Defined Contribution) needs to be refined to meet the needs and expectations of users
- TPA’s currently leverage a Proposal System to help with the calculations for small business employers to help scope the costs associated with selecting certain plans / contribution amounts
- Average age of the group is the industry standard for rate generation
- Exchange should utilize standard enrollment levels (Individual, Individual +1, Family, etc.)

Eligibility & Enrollment

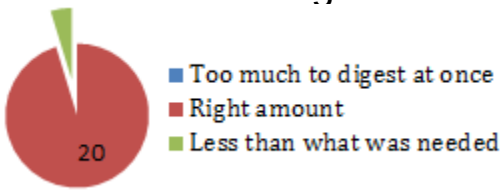
Key Findings:

- Exchange needs to have ability to capture disability status of individuals
- Unique identifier component requires additional thought as the “churn” aspect of the marketplace introduces additional levels of complexity in traceability of individuals
- Address information / changes and verifying such information is currently a big challenge
- Would be helpful to conduct an 834-Form crosswalk to try to introduce a standardized enrollment form across the Exchange / Carriers / TPA’s / etc.
- Deductible is the key component individuals utilize when comparing and filtering plan selections
- Satisfaction Rating mechanism introduces a challenge in ensuring the source/data is fair and equitable
- Who pays credit card company fees?
- Individuals are accustomed to viewing a “Summary of Benefit and Coverage” vice the detailed components of various health plans
- Maryland needs to standardize tiers of plan coverage that will be available on the Exchange

JAD Session Survey Results

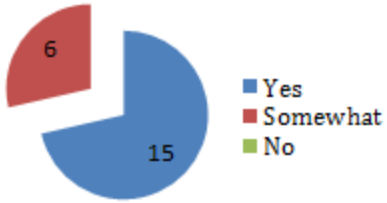
1. How would you rate the amount of information covered during the JAD session?

a	Too much to digest at once	0
b	Right amount	20
c	Less than what was needed	1
Total		**21**



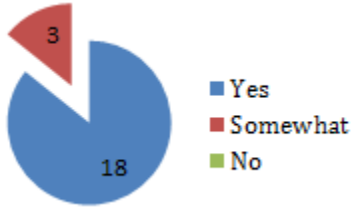
2. Do you feel the content covered in the JAD session was beneficial to defining the Eligibility and Enrollment requirements/process?

a	Yes	15
b	Somewhat	6
c	No	0
Total		**21**



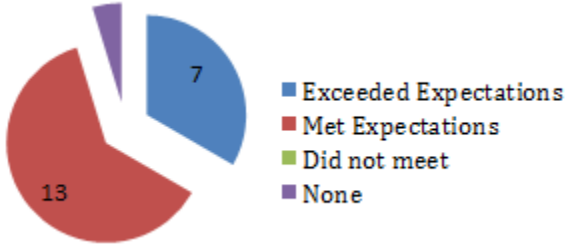
3. Do you feel the JAD session was effective?

a	Yes	18
b	Somewhat	3
c	No	0
Total		**21**



4. How would you rate the effectiveness of the facilitators?

a	Exceeded Expectations	7
b	Met Expectations	13
c	Did not meet	0
d	None	1
Total		**21**



SHOP Update

Schedule Review / Next Steps

Next Steps

EIAC Meeting Schedule

- Meetings will occur on a bi-weekly basis.
- If no updates are available, we will cancel the meeting.
- Please provide us with topics that you want more information on or that you think the Exchange should be considering.

Next Steps

JAD Session Schedule

•Billing and Payment

March 14, 2012 2:00PM - 5:00PM (EST)

Premium Payment Tracking, Insurance Carrier / TPA Management

•Customer Support

March 20, 2012 2:00PM - 5:00PM (EST)

Agent / Navigator Management, Call Centers

•Reporting, Transparency, & Notifications

March 27, 2012 2:00PM – 5:00 PM (EST)

Reporting and Notification Requirements and Channels, Transparency Data and Reporting

All JAD Sessions will take place at the UMBC TechCenter:

1450 S. ROLLING ROAD

BALTIMORE, MD 21227-3898

Thank you for your support !!!